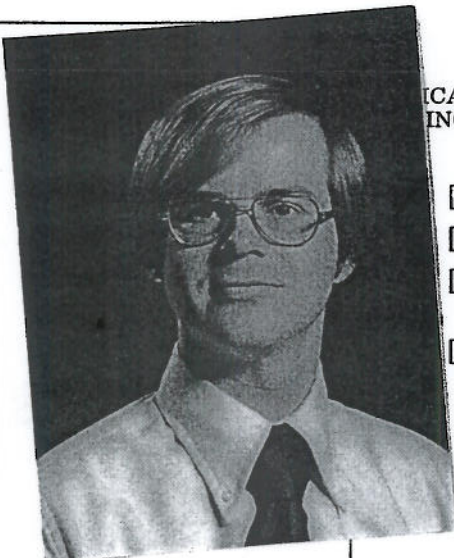


GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF ECONOMIC DEVELOPMENT
OFFICE OF LICENSES AND PERMITS
OCCUPATIONAL AND PROFESSIONAL LICENSING DIVISION
614 H Street, N.W.
Washington, D.C. 20001

Commission on Licensure to Practice The Healing Art



APPLICATION FOR LICENSE TO PRACTICE THE
HEALING ART IN THE DISTRICT OF COLUMBIA

- [] Examination
[] Endorsement of FLEX
[✓] Endorsement of National Board Diploma
[] Reciprocity
(Check One)

01157

FOR OFFICIAL USE ONLY	
APPL. NO.	
EXAM DATE	<u>75-9N-99</u>
LICENSE NO.	<u>7639</u>
DATE ISSUED	<u>12/24/74</u>
DENIED	
REMARKS	

METHOD OF HEALING (Check one): [] Osteopathy & Surgery [✓] Medicine & Surgery [] Chiropractic [] Other (Explain)

1. NAME: First Robert Middle Allan Maiden Last Gatlin

2. BIRTHDAY: Month 10 Day 15 Year 1936 3. BIRTHPLACE: City Stockton County Calif. State Calif.

4. CURRENT ADDRESS: Number 234 Street Goodman City Cincinnati State Ohio Zip Code 45229 Phone No. 766-5461

Duration of residence at above address: From June 15, 1974 To

5. EDUCATION (including Pre-Medical)		Dates Attended		Degree Received
Name of College or University	Location	From	To	
University of the Pacific	Stockton, Calif.	1965	1967	
Leland Stanford Junior Univ.	Stanford, Calif.	1967	1969	B. A.
The George Washington Univ.	Washington, D.C.	1969	1973	M. D.

6. TRAINING AND PRACTICE since date of graduation to the present. Include periods of unemployment and other employment.			
Employer	Address	From	To
Cincinnati General Hospital of the Univ. of Cincinnati Medical Center	234 Goodman Street Cincinnati, Ohio 45229	7-1-73	6-30-74

7. REFERENCES: List the names and full mailing addresses of 3 personal acquaintances, not relatives, who have knowledge of your character and professional practice; or give the name and address of the chartered State or County Medical Society or other Society nearest your residence.

NAME	ADDRESS
Mr. & Mrs. Richard Resseger	[REDACTED]
Dr. & Mrs. Kenneth Travers	[REDACTED]
Dr. Howard Sokolov	Dept. of Psychiatry Cincinnati General Hospital Cincinnati, Oh.

8. PREVIOUS LICENSURE: Give the following information concerning the license on which reciprocity is requested. (If no previous licensure, indicate "none".)

Jurisdiction of Issuance	License Number	Date of Issue	Basis
None			

Give complete mailing address of the board which issued the above license:

9. State specifically the specialty, if any, and the limit of such specialty:

10. HAS LICENSE EVER BEEN DENIED BY ANY BOARD, OR SUSPENDED, REVOKED, OR SURRENDERED FOR ANY REASON? No If "Yes", give full details on an attached sheet.

11. DECLARATION OF INTENT: As a part of my application for a reciprocal license to practice the Healing Art in the District of Columbia, I hereby declare that it is my intention, if issued a license, to practice the Healing Art in the District of Columbia, in accordance with Section 2-121, D.C. Code, 1967 Edition.

12. If endorsement of FLEX certificate is requested, give date and place of examination:

13. HAVE YOU EVER BEEN ARRESTED, INDICTED, OR CONVICTED OF ANY CRIME (other than minor traffic violations)? No If "Yes", give full details on attached sheet.

14. HAVE YOU EVER TAKEN AN EXAMINATION IN THE BASIC SCIENCES OR ANY EXAMINATION IN THE HEALING ART UNDER THE AUTHORITY OF THE COMMISSION ON LICENSURE TO PRACTICE THE HEALING ART IN THE DISTRICT OF COLUMBIA? No If "Yes", give date and type of examination:

15. APPLICANT'S CERTIFICATION

I hereby certify that the statements contained in the foregoing application are true and that I am the identical person whose history of education, practice of medicine, or otherwise, is contained herein.

It is understood and agreed by the applicant that any information contained in this application may be furnished to any State Medical Board or similar organization having an official and legitimate need for same.

Signature of Applicant: Robert A. Gathlin, M.D. Date: July 20, 1974

SUBSCRIBED AND SWORN TO BEFORE ME THIS 20 DAY OF July, 1974

Signature of Notary Public

(Seal of Notary Public)

University of Cincinnati Medical Center

Cincinnati General Hospital

This is to certify that

Robert A. Gallin

served in this Hospital as

Junior Resident Psychiatrist

July 1, 1973 to July 1, 1974

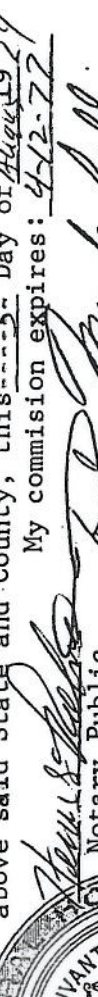

IN WITNESS WHEREOF, we have hereunto affixed
our names and attached the official seal of the Hospital.

This is a true and correct copy of the original diploma issued by University of Cincinnati Medical Center to
Robert A. Gatlin from July 1, 1973 to July 1, 1974


Robert A. Gatlin


Chairman, Directing Medical Staff



sworn to me Herman L. Roberts, a Notary Public in and for the
State of Virginia, County of Fairfax: Subscribed and
above said State and County, this 3 Day of August 1974
My commission expires: 4-12-77

Notary Public

Administrator


Director of Service

July 1, 1974

H E A L I N G A R T

PROCESSING CHECKLIST

NAME

Gather, Robert AllanApplications Clerk

1. Is application form signed and notarized
2. Is photograph attached
3. Is internship certificate (or notarized copy) or certified statement from internship hospital (except Reciprocity)
4. Notarized copy of medical diploma or certified copy or medical school transcript (except Reciprocity)
5. Notarized copy of ECFMG Certificate (foreign grade only)
6. Fee attached
7. File folder attached (Re-examination applicants only)

(Applications Clerk)

Applications Examiner

1. Applicant is at least 21 years old
2. Applicant has accounted for all practice since M.D. degree or (Reciprocity only) since issue of base license
3. Method of healing (indicate)
4. Applying for license by (indicate)
5. (Examination applicant only)
 - a. Applicant asks exemption from Basic Sciences
 - b. Questions have been received directly from other Board
6. (Reciprocity applicant only)
 - a. Written licensing examination by (indicate)
 - b. Has provided information re base license
 - c. Has practiced at least one year out of the last three years immediately prior to this application since issue of base license
 - d. Applicant has been previously examined in District of Col. (yes or no)
- (1) Exam taken and failed here before base license
- (2) Exam taken and failed here after base license
7. Applicant has submitted proper fee (amount)

(Applications Examiner)

(OVER)

Disposition

1. Returned to applicant _____ by _____
(date) (initials)

2. Accepted. Form 52 prepared _____
(initials)

Applications Clerk

1. _____
- 1 Assign application number and enter in journal _____
- 2 Process fee _____
- 3 Prepare file envelope _____
- 4 Forward Form 52 _____
5. File envelope in "pending" file _____
(Applications Clerk)

Review of Investigation

1. AMA clearance received _____
2. Police clearance received _____
3. Satisfactory references received _____
4. Grades received and approved (National Board and FLEX only) _____
5. Licensure verified and reciprocity statement received _____

(Applications Examiner)

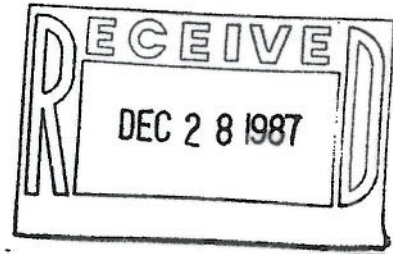
EXAMINER COMMENTS:

COMMISSION COMMENTS AND ACTION

DATE:

GOVERNMENT OF THE DISTRICT OF COLUMBIA
BOARD OF MEDICINE
605 G STREET, N.W., ROOM 202—LOWER LEVEL, WASHINGTON, D.C. 20001

ADDRESS ALL COMMUNICATIONS
TO THE BOARD



DISCIPLINARY INQUIRIES

Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102-7999

The Commission on Licensure to Practice ^{the Healing Art} requests a disciplinary search concerning the following individual:

Name Robert A. Gatlin, M.D.

Address [REDACTED]

City, State and Zip [REDACTED]

Date of Birth Feb. 10, 1947

Social Security Number [REDACTED]

The George Washington University
Medical School of Graduation and Branch Location

Date of Graduation May 27, 1973

Please mail the response to the following address:

Board of Medicine

605 G Street N.W. Rm#LL202

Washington, D.C. 20001

ATTENTION: _____

Robert A. Gatlin, M.D.
Signature

WE HAVE NO UNFAVORABLE INFORMATION
REGARDING THE ABOVE NAMED PHYSICIAN

DEC 31 1987

Bryant L. Galusha, M.D.
BRYANT L. GALUSHA, M.D.
EXECUTIVE VICE-PRESIDENT

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF ECONOMIC DEVELOPMENT
OFFICE OF SPECIAL OPERATIONS
614 H STREET, N.W., WASHINGTON, D.C. 20001

William L. Durrer, Chief
Fairfax County Police
Fairfax, Virginia 222030



Date: Nov. 11, 1974

Dear Sir:

The Department of Economic Development is the issuing agency in the District of Columbia for various licenses and permits and is charged with the responsibility of investigating individuals applying for or holding licenses with the Department.

An investigation is being conducted concerning an individual with the following identifying factors:

NAME:	First	Middle	(Maiden)	Last	
	Robert	Allan		Gatlin	
Age	Race	Male	Place of Birth	Date of Birth	
		Female	[REDACTED]	[REDACTED]	
Height	Weight	Eyes	Scars	Marks	Tattoos
Occupation (s)					
Healing Arts					
Residence (former)					
[REDACTED]					

It will be appreciated if you will search your criminal identification records for information on this individual and notify us as soon as possible of the date, charge and disposition of each arrest found. In the case of a felony conviction, within the past ten years, please advise us of the name and address of the court wherein the conviction was obtained.

Please be assured of the cooperation of this office whenever requested.

weber/dap
Investigator.....
License..... Healing Arts

C. MARVIN WARD
Administrator

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF ECONOMIC DEVELOPMENT
OFFICE OF SPECIAL OPERATIONS
614 H STREET, N.W., WASHINGTON, D.C. 20001



11/11/74

Dr. & Mrs. Kenneth Travers
[Redacted]
Greenbelt, Maryland

Applicant.....Robert A. Gatlin..
Address.....[Redacted]..
[Redacted].....

TO WHOM IT MAY CONCERN:

The applicant whose name and address are given above has applied for a reciprocal license to practice the healing art in the District of Columbia. This voucher is being forwarded to you regarding his moral character and professional experience.

Your prompt return of this voucher, properly executed and signed by you, will greatly assist the Commission when considering his application for license. Your reply will be considered as confidential information by the Commission.

The Commission on Licensure to Practice the Healing Art will expect any person signing this voucher to understand that the Commission is required, by law, to obtain evidence of the good character of applicants for license as a Medical Doctor. Statements by responsible persons with actual knowledge of the applicant's character and experience will be considered by the Commission as evidence in this regard.

Practice in the medical profession involves relations with the public that necessitate a high degree of honor, integrity and professional ability. Therefore, the Commission desires the person subscribing to this voucher to understand fully that the purpose of the law requiring a license is to protect the public from the practice of medicine by persons whose character is questionable or who are not competent to engage in such practice.

PLEASE RETURN THIS VOUCHER TO:

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Economic Development
Office of Special Operations
614 H. Street, N. W.
Washington, D. C. 20001

CITIZEN'S VOUCHER

.....November 15, 1974.....

TO THE COMMISSION ON LICENSURE, HEALING ARTS PRACTICE ACT, D.C. :

I hereby certify that since.....September 1969....., I have been
(INSERT DATE)
so closely associated with Dr. Robert Gatlin....., residing
(APPLICANT'S NAME)
in....., as to be able to intelligently express
(CITY AND STATE)
an opinion as to his character, mental condition, and habits, and that to the best
of my knowledge and belief, he is of good moral character and free from mental de-
fects and drug habits liable to interfere with the proper practice of the healing
art.

I certify further that to my personal knowledge he has been actually engaged
in the practice of.....for not less than one continuous year
immediately preceding.....11/15/74.....
(DATE OF APPLICATION)

Remarks:
.....
.....

.....Physician.....
(PROFESSION OR BUSINESS)

.....C. Kenneth Travers, Jr. M.D.....
(NAME-PRINT OR TYPE)

.....C. Kenneth Travers, Jr. M.D.....
(SIGNATURE)

.....
(ADDRESS)
.....

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF ECONOMIC DEVELOPMENT

OFFICE OF SPECIAL OPERATIONS

614 H STREET, N.W., WASHINGTON, D.C. 20001



11/11/74

Dr. Howard Sokolov
Dept. of Psychiatry
Cincinnati General Hospital
Cincinnati, Ohio

Applicant Robert A. Gatlin...

Address [REDACTED].....

TO WHOM IT MAY CONCERN:

The applicant whose name and address are given above has applied for a reciprocal license to practice the healing art in the District of Columbia. This voucher is being forwarded to you regarding his moral character and professional experience.

Your prompt return of this voucher, properly executed and signed by you, will greatly assist the Commission when considering his application for license. Your reply will be considered as confidential information by the Commission.

The Commission on Licensure to Practice the Healing Art will expect any person signing this voucher to understand that the Commission is required, by law, to obtain evidence of the good character of applicants for license as a Medical Doctor. Statements by responsible persons with actual knowledge of the applicant's character and experience will be considered by the Commission as evidence in this regard.

Practice in the medical profession involves relations with the public that necessitate a high degree of honor, integrity and professional ability. Therefore, the Commission desires the person subscribing to this voucher to understand fully that the purpose of the law requiring a license is to protect the public from the practice of medicine by persons whose character is questionable or who are not competent to engage in such practice.

PLEASE RETURN THIS VOUCHER TO:

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Economic Development

Office of Special Operations

614 H. Street, N. W.

Washington, D. C. 20001

CITIZEN'S VOUCHER

November 20, 1974

TO THE COMMISSION ON LICENSURE, HEALING ARTS PRACTICE ACT, D.C. :

I hereby certify that since July 1, 1973 (INSERT DATE), I have been so closely associated with Dr. Robert A. Gattin, residing in Cincinnati, Ohio (CITY AND STATE), as to be able to intelligently express an opinion as to his character, mental condition, and habits, and that to the best of my knowledge and belief, he is of good moral character and free from mental defects and drug habits liable to interfere with the proper practice of the healing art.

I certify further that to my personal knowledge he has been actually engaged in the practice of Medicine (Psychiatry) for not less than one continuous year immediately preceding July 74 (DATE OF APPLICATION)

Remarks:

Medicine (Psychiatry) (PROFESSION OR BUSINESS) Howard H. Sokolov M.D. (NAME-PRINT OR TYPE)

Howard H. Sokolov (SIGNATURE)

(ADDRESS)

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF ECONOMIC DEVELOPMENT
OFFICE OF SPECIAL OPERATIONS
614 H STREET, N.W., WASHINGTON, D.C. 20001



11/11/74

Mr. & Mrs. Richard Resseger
[REDACTED]

Applicant..... Robert A. Gatlin

Address.....
[REDACTED]

TO WHOM IT MAY CONCERN:

The applicant whose name and address are given above has applied for a reciprocal license to practice the healing art in the District of Columbia. This voucher is being forwarded to you regarding his moral character and professional experience.

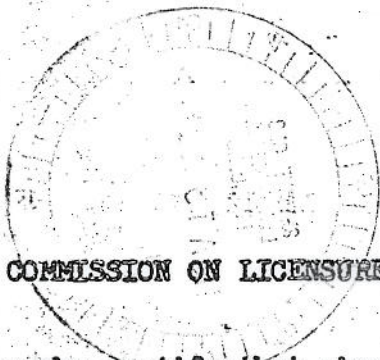
Your prompt return of this voucher, properly executed and signed by you, will greatly assist the Commission when considering his application for license. Your reply will be considered as confidential information by the Commission.

The Commission on Licensure to Practice the Healing Art will expect any person signing this voucher to understand that the Commission is required, by law, to obtain evidence of the good character of applicants for license as a Medical Doctor. Statements by responsible persons with actual knowledge of the applicant's character and experience will be considered by the Commission as evidence in this regard.

Practice in the medical profession involves relations with the public that necessitate a high degree of honor, integrity and professional ability. Therefore, the Commission desires the person subscribing to this voucher to understand fully that the purpose of the law requiring a license is to protect the public from the practice of medicine by persons whose character is questionable or who are not competent to engage in such practice.

PLEASE RETURN THIS VOUCHER TO:

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Economic Development
Office of Special Operations
614 H. Street, N. W.
Washington, D. C. 20001



CITIZEN'S VOUCHER

November 16, 1974

TO THE COMMISSION ON LICENSURE, HEALING ARTS PRACTICE ACT, D.C. :

I hereby certify that since April 28, 1970, I have been
(INSERT DATE)
so closely associated with Dr. Robert A. Gatlin, MD, residing
(APPLICANT'S NAME)
in [REDACTED], as to be able to intelligently express
(CITY AND STATE)
an opinion as to his character, mental condition, and habits, and that to the best
of my knowledge and belief, he is of good moral character and free from mental de-
fects and drug habits liable to interfere with the proper practice of the healing
art.

I certify further that to my personal knowledge he has been actually engaged
in the practice of "OBGYN" for not less than one continuous year
immediately preceding November 11, 1974
(DATE OF APPLICATION)

Remarks: OBGYN is an abbreviation for Obstetrics and Gynecology, which the applicant has been engaged in as above stated.

Systems Analyst
(PROFESSION OR BUSINESS)

Sperry- Univac
2121 Wisconsin Ave, NW
Washington, DC 20007

Richard E. Ressegger
(NAME-PRINT OR TYPE)

Richard E. Ressegger
(SIGNATURE)

[REDACTED]
(ADDRESS)

NATIONAL BOARD OF MEDICAL EXAMINERS

3930 CHESTNUT STREET, PHILADELPHIA, PENNA. 19104

CERTIFICATION OF RECORD

To: Government of the District of Columbia
Department of Economic Development
Office of Special Operations
614 H. Street, M. W.
Washington, D.C. 20001

Robert Allan Gatlin, M. D.

THIS CERTIFIES THAT

has successfully completed all examinations required for certification by the National Board of Medical Examiners and that his grades were as shown below.

In accordance with announcements made by the National Board of Medical Examiners, grades obtained on National Board examinations are being reported in terms of standard scores, rather than scale scores. This scoring system was initiated with the Part I examination of June, 1971, and will be applied to all subsequent examinations in Part I, Part II and Part III.

Because candidates normally take the various Parts of the National Board examination at different times, it is recognized that for a few years some individuals will have standard-score grades for one section of the test and scale-score grades for other sections. Therefore, until such time as all three sections of the test can be reported in terms of standard scores for all candidates, both standard-score grades and their scale-score equivalents are provided for examinations for which the official report is recorded in standard-score terms (June, 1971 and later).

The National Board criterion for certification is based upon the candidate's total grade in Part I, Part II and Part III. Scores in individual subjects within each Part (e.g., Anatomy, Physiology, Medicine, Pediatrics, etc.) are not considered in determining whether the candidate has passed the Part. Therefore, official "pass-fail" scores are established for the total grade on each Part, but not for individual subjects within the Part.

Part I		Part II		Part III	
Scale Score	Standard Score	Scale Score	Standard Score	Scale Score	Standard Score
Anatomy, incl. histology and embryology		Internal medicine and the medical specialties		A General Test of Clinical Competence	
Physiology		Surgery and the surgical specialties			
Biochemistry		Obstetrics and Gynecology			
Pathology		Public Health and Prev. Med.			
Microbiology, incl. immunology		Pediatrics			
Pharmacology and Materia Medica		Psychiatry			
TOTAL TEST		TOTAL TEST			
Passing Score (Total Test)		Passing Score (Total Test)			

Part I passed June, 1971
Part II passed April, 1973
Part III passed March, 1974
General Average (Scale Score)
Certificate No. 133754
Certificate dated July 1, 1974

SEAL

Ann K. Leverling
Secretary for Certification

November 22, 1974

Date

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

CIRCULATION AND RECORDS DEPARTMENT
PHYSICIAN'S HISTORICAL RECORD

DATE: 11-26-74
TIME: 2:02 PM
MEDICAL EDUCATION NUMBER: 01001731013
20037

NAME: GATLIN, ROBT ALLAN, M.D.
ADDRESS: GEO WASHINGTON U HOSP-OBG
BIRTHPLACE: [REDACTED]

WASHINGTON DC
BIRTHDATE: [REDACTED]

MEDICAL EDUCATION (SCHOOL YEAR):

GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE, WASHINGTON .
NATIONAL BOARD CERTIFICATION: 1974

1973

LICENSES:

NONE REPORTED TO DATE

PHYSICIAN'S PROFESSIONAL ACTIVITIES:

RESIDENT

PRIMARY SPECIALTY: OBSTETRICS AND GYNECOLOGY

SECONDARY SPECIALTY: UNSPECIFIED

TERTIARY SPECIALTY: UNSPECIFIED

SPECIALTY BOARD CERTIFICATION: NONE REPORTED TO DATE

MEMBER OF AMA: NOT MEMBER

NATIONAL SCIENTIFIC MEDICAL SOCIETIES: NONE REPORTED TO DATE

PROFESSORIAL APPOINTMENT: NONE REPORTED TO DATE

CURRENT MEDICAL TRAINING: RESIDENT

HOSPITAL: GEO WASHINGTON U HOSP

WASHINGTON

20037

DATES OF TRAINING: 07/74-06/75

SPECIALTY: OBSTETRICS AND GYNECOLOGY

SPECIALTY: UNSPECIFIED

INTERNSHIP:

NONE REPORTED TO DATE

RESIDENCY:

HOSPITAL: CINCINNATI GEN HOSP

CINCINNATI

45229

DATES OF TRAINING: 07/73-06/74

SPECIALTY: PSYCHIATRY

SPECIALTY: UNSPECIFIED

BIOGRAPHICAL DATA ON PHYSICIANS

from the Biographical - Historical files of
American Medical Association
535 N. Dearborn St.
Chicago, Illinois 60610

11/11/74

This form is provided for your convenience in making routine inquiries regarding physicians seeking medical licensure in your state, hospital staff privileges or faculty positions. Please enter on this form data you wish verified and mail to the Member Services Unit of the AMA.

Full name of M.D. Robert Allan Gatlin

Place of birth [REDACTED] Date of birth [REDACTED]

Professional Mailing Address 156 Evans Court, Falls Church, VA 22044

Medical Education:

School Name George Washington Univ.-Washington, D. C. M.D. Degree 69-73
(Year)

Internships:

Hospital	Location	Dates
		to
		to

Residencies and Fellowships:

Hospital	Location	Dates
		to
		to

M.D. Licensed to Practice Medicine in the Following States:

State _____ Year _____; State _____ Year _____; State _____ Year _____

Inquiry Submitted by _____ Title _____
(Your Name Here)

Dept. of Economic Development, 614 H Street, NW City-State Washington, D.C. 20001
(Affiliation - Licensing Board, Hospital or Medical School)

AMA Department of Investigation

MEMBER OF AMA

..... YES

- ☐ Our records do not reveal any derogatory information.
☐ See attached memo for comments regarding applicant.

..... NO

A check mark (✓) indicates that the data given corresponds to that listed in the AMA Master File of Physicians. Any discrepancies are as noted.

Date _____

Joan Alvarez
Joan Alvarez,
Member Services Unit